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IN THE SUPERIOR COURT OF CALIFORNIA

IN AND FOR THE COUNTY OF SAN FRANCISCO

ROBERT MARTIN and DEBORAH GOODWIN, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

CALIFORNIA PHYSICIANS' SERVICE, d/b/a BLUE SHIELD OF CALIFORNIA; BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY; and DOES 1-25,

Defendants.

Case No. CGC-12-521539

CLASS ACTION COMPLAINT

(1) Violations of California Business & Professions Code § 17200 *et seq. (Unlawful)*

(2) Violations of California Business & Professions Code § 17200 *et seq. (Unfair)*

(3) Violations of California Business & Professions Code § 17200 *et seq. (Fraudulent)*

(4) Violation of Consumers Legal Remedies Act, Cal. Civ. Code § 1750 *et seq.*

(5) Breach of Contract

(6) Declaratory Relief

(7) Breach of the Implied Covenant of Good Faith and Fair Dealing

(8) Common Counts/Common Law Restitution, and *Assumpsit*

Jury Trial Demanded

Plaintiffs, by their attorneys, bring this action on behalf of themselves and all others similarly situated against Defendants California Physicians' Service dba Blue Shield of California and Blue Shield of California Life & Health Insurance Company (hereafter collectively "Blue Shield" or "Defendants"). Plaintiffs allege the following on information and belief, except as to those allegations that pertain to the named Plaintiffs, which are alleged on personal knowledge:

NATURE OF THE ACTION

1. Plaintiffs bring this action to challenge Blue Shield's closure and manipulation of blocks of health insurance business[1] with the apparent intention of illegally decreasing policy benefits to enrollees while escalating the premiums they must pay in violation of Health and Safety Code and Insurance Code block closure provisions specifically prohibiting these practices.

2. Blue Shield has used enormous rate increases, and the threat of rate increases, while closing all but one high-deductible health plan or policy block of business to force patients into lower-benefit coverage, in violation of state law. Additionally, Blue Shield is engaged in illegal gaming of California's dual-regulator health insurance system[2] by alternately closing older blocks of business under one agency and opening new blocks under the other agency in order to push older, sicker consumers into lower-benefit, higher-deductible coverage. These high deductible health plans and policies require consumers to pay more money out-of-pocket for medical care before Blue Shield pays for any medical benefits. Many consumers are priced out of health care coverage altogether and left uninsured.

[1] As set forth in Health & Safety Code section 1367.15, subdivision (b) and Insurance Code section 10176.10, subdivision (b), "block of business" means individual plan contracts and policies.

[2] Two regulatory agencies – the California Department of Managed Health Care ("DMHC") and the California Department of Insurance ("CDI") oversee the different segments of Blue Shield's insurance business at issue in this action. Coverage regulated by the DMHC will be referred to as a "health plan." Coverage regulated by the CDI will referred to as a "policy." "Enrollees" and "policyholders" include individuals with DMHC or CDI coverage.

3. The impact of Blue Shield's practice of closing blocks of business is known as a "Death Spiral." A "Death Spiral" occurs when an insurer ceases to offer a block of business to new applicants. Consumers in the closed blocks with pre-existing health conditions are unable to obtain alternative health coverage at all, or may only be given the option to transfer to health plans or policies that offer lesser benefits and higher deductibles. Consumers with pre-existing medical conditions cannot seek other comparable coverage because they cannot pass "medical underwriting," the process through which a health care service plan or health insurer evaluates a consumer's insurance risk, and on that basis, determines whether to sell coverage to that individual.[3] Thus, the closed plan, without new applicants, becomes a plan or policy consisting largely of unhealthy and older members. Since rates are set based on the medical experience of a block of business, rates in those closed blocks "spiral" up over time.[4] Eventually, many enrollees are priced out of coverage and are frequently left uninsured.

4. Blue Shield's conduct violates section 1367.15 of the Health & Safety Code and section 10176.10 of the Insurance Code, which mandate that, in order to close a block of business, health care service plans licensed by the Department of Managed Health Care ("DMHC") and health insurers licensed by the Department of Insurance ("CDI") must either (1) pool the experience of the individuals in the closed blocks with the experience of enrollees in an appropriately large number of open blocks of business in order to calculate premium rates, or (2) offer enrollees in closed blocks of business to switch to alternative coverage in open blocks of business with comparable benefits. As a result of leaving open only one non-comparable health plan or policy block within the DMHC and CDI at time of closure, Blue Shield has neither properly pooled its enrollees for purposes of calculating premiums nor offered enrollees comparable coverage. Blue Shield also has not provided any notice to consumers that it has closed or is closing such health plans and policies, nor has Blue Shield provided consumers

[3] Health insurers use medical underwriting to deny coverage to consumers for even very minor health problems—including those with allergies and acne—thereby making it more likely that a large population of insureds are potentially susceptible to the Death Spiral. Press Release, Consumer Watchdog, Internal Documents Show Insurers Won't Sell Health Policies to Cops, Firefighters, Expectant Dads, Allergy & Acne Sufferers (Jan. 8, 2007), *available at* http://www.consumerwatchdog.org/patients/articles/?storyId=15166

[4] Consumer Services Agency, Enrolled Bill Report on AB 1743, September 15, 1993 (AB 1743 codified the Death Spiral Statute.)

information about their option to switch to comparable coverage. Blue Shield's conduct is unlawful, unfair and fraudulent, and therefore violates California Business & Professions Code section 17200 *et seq.,* as well as the Consumers Legal Remedies Act ("CLRA"), Civil Code section 1750 *et seq*. Blue Shield's conduct also breaches uniform express or implied contractual provisions between Blue Shield and Plaintiffs and Class Members and the implied covenant of good faith and fair dealing.

5. Plaintiffs bring this action on behalf of themselves and also on behalf of a class of California residents who are: (i) currently enrolled in an individual Blue Shield health plan contract or who were enrolled in an individual Blue Shield health plan contract closed in March 2010; and, (ii) consumers who are enrolled in a Blue Shield policy that Blue Shield has threatened to close as of July 2, 2012 ("Class").

6. Plaintiffs seek an order of this Court enjoining Blue Shield's continued violations of law as set forth herein. Plaintiffs also seek restitution and disgorgement of excess premiums calculated and collected from policyholders in violation of California law, and other remedies as set forth herein.

THE PARTIES

7. Plaintiff Robert Martin is a resident of Gilroy, California. Mr. Martin was an enrollee in a Blue Shield "Shield Spectrum PPO 2000"[5] health plan contract subject to Health & Safety Code section 1367.15 that was closed to new members as of March 2, 2010.

8. Plaintiff Deborah Goodwin is a resident of Santa Monica, California. Ms. Goodwin is currently enrolled in a Blue Shield "Shield Savings 1800/3600 PPO" policy, which is subject to Insurance Code section 10176.10 and according to Blue Shield's website is to be closed to new members as of July 2, 2012.

9. Defendant California Physicians' Service dba Blue Shield of California is a corporation duly organized and existing under the laws of the State of California, with its principal place of business located in San Francisco, California. It is authorized to transact and is transacting the business of providing health coverage throughout this State. California Physicians'

[5] In this Complaint, numeric values in health plan and policy names denote the annual deductible.

Service dba Blue Shield of California is a "health care service plan" regulated by the DMHC.

10. Blue Shield Life & Health Insurance Company is a wholly owned subsidiary of California Physicians' Service and is a corporation duly organized and existing under the laws of the State of California, with its principal place of business located in San Francisco, California. It is authorized to transact and is transacting the business of providing health insurance throughout this State. Blue Shield Life & Health Insurance Company is a health insurer regulated by the CDI.

11. The true names, roles and capacities of Defendants named as Does 1 through 25, inclusive, are currently unknown to Plaintiffs and, therefore, are named as Defendants under fictitious names pursuant to California Code of Civil Procedure section 474. Plaintiffs will identify their true identities and their involvement in the wrongdoing at issue if and when they become known. Defendants' conduct described herein was undertaken or authorized by Blue Shield's officers or managing agents who were responsible for supervision and operations decisions. The described conduct of said managing agents and individuals was therefore undertaken on behalf of Blue Shield. Blue Shield further had advance knowledge of the actions and conduct of said individuals whose actions and conduct were ratified, authorized, and approved by managing agents. Their precise identities are unknown to Plaintiffs at this time and are therefore identified and designated herein as Does 1 through 25.

JURISDICTION AND VENUE

12. This Court has jurisdiction over this action under Article VI, section 10 of the California Constitution and section 410.10 of the Code of Civil Procedure. Jurisdiction is also proper under Business & Professions Code section 17200 *et seq.*

13. This Court has jurisdiction over Blue Shield, which is a resident of the State of California.

14. Jurisdiction over Blue Shield is also proper because Blue Shield has purposely availed itself of the privilege of conducting business activities in California and because Blue Shield currently maintains systematic and continuous business contacts with this State, and has many thousands of health plan members and policyholders who are residents of this State and who do business with Blue Shield.

15. Plaintiffs do not assert any claims arising under the laws of the United States of America. The amount in controversy in this action does not exceed $74,999 with respect to the Plaintiffs' claim or the claim of each Class Member. Moreover, all Class Members are currently residents of the State of California as are the Defendants, such that there is no diversity of citizenship between the parties.

16. Venue is proper in this Court because Plaintiffs and many Class Members did business with Blue Shield in this County, Blue Shield's principal places of business are located in this County and substantial transactions took place in this County, and because Blue Shield received substantial profits from policyholders who reside in this County.

STATUTORY AND REGULATORY SCHEME

17. Since 1993, California has regulated health insurance industry practices that result in a Death Spiral for one or more individual health plan contracts or policies with distinct benefits, services and terms (a "block of business").

18. Acting in response to the deleterious impact of the Death Spirals resulting from practices utilized by health care service plans and health insurers doing business in California, the California legislature passed AB 1743 in 1993.

19. According to the letters sent by the Department of Corporations to legislators urging their support of the legislation, the statute was written to correct "[a] pernicious business practice that has the result of forcing individual policyholders into the ranks of the uninsured when they need health care the most."[6]

20. In fact, Blue Shield's Death Spiral practices were the catalyst for the 1993 statute:

> The Department of Corporations[7] has received complaints regarding this business practice, especially complaints in connection with Blue Shield of California. Blue Shield's practice was also identified in a July 1992 report to the Insurance Commissioner by the Task Force in HIV/AIDS Insurance Issues.[8]

[6] Senior Corporations Counsel Timonthy L. Le Bas, Department of Corporations, letter to Assemblyman John Vasconcellos, ("Department of Corporations Letter"), April 30, 1993, p. 1, (Attached as Exhibit 1 is a true and correct copy of the Department of Corporations Letter, which is incorporated herein by reference.)

[7] The Department of Corporations had jurisdiction over health care service plans prior to the DMHC.

[8] Legislative Analysis on AB 1743, Department of Corporations, ("Legislative Analysis"), March 23, 1993, p. 2, (Attached as Exhibit 2 is a true and correct copy of the Legislative Analysis, which is incorporated herein by reference.)

21. The legislative committee analysis states that the purpose of AB 1743 was:

> [T]o address the problems experienced by people who have health coverage under "closed" plans and find themselves subjected to spiraling rate increases. An insurer "closes" a block of business by no longer offering that particular policy form or contract to new applicants. Since insurers generally require medical underwriting before accepting an applicant for coverage, those persons covered under closed plans, who happen to have pre-existing conditions, find themselves locked into the closed plan. . . . Over time, only unhealthy people are left in the closed plan, which leads to even higher rates. Insurer practices in this regard have been termed the "death spiral." Because rates inevitably increase to the point at which a policyholder can no longer afford coverage.[9]

22. AB 1743 was codified as section 1367.15 of the Health & Safety Code and section 10176.10 of the Insurance Code (collectively, the "Death Spiral Statute.")

23. Section 1367.15 of the Health & Safety Code applies to "individual health care service plan contracts" and to "plan contracts sold to employer groups, with fewer than two eligible employees . . . covering hospital, medical, or surgical expenses which is issued, amended, delivered, or renewed on or after January 1, 1994." (Health & Saf. Code § 1367.15(a).). Insurance Code section 10176.10, subdivision (a) contains a similar definition. The health plans and policies at issue in this action fall within these definitions. Thus, members of the Class have rights created and recognized by the statutes that Blue Shield has either violated or imminently threatens to violate.

24. A "closed block of business" is defined as "a block of business for which a health care service plan ceases to actively offer or sell new plan contracts." (Health & Saf. Code § 1367.15(b); *see also* Ins. Code § 10176.10(b).) The Death Spiral Statute also identifies those situations in which a block of business will be presumed closed. The health plans and policies in which Plaintiffs, and other similarly situated consumers included within the Class, either were or are enrolled in fall (or within weeks will fall) within the definition of a closed block of business.

25. Section 1367.15, subdivision (c) contains the requirements for closing a block of business. Insurance Code section 10176.10, subdivision (c) contains a similar provision applicable to health insurance policies.

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[9] Assembly Committee on Insurance, Hearing on AB 1743 (Margolin), Committee Analysis, ("Committee Analysis"), April 20, 1993, pp. 1-2, (Attached as Exhibit 3 is a true and correct copy of the Committee Analysis, which is incorporated herein by reference.)

> No block of business shall be closed by a health care service plan unless (1) the plan permits an enrollee to receive health care services from any block of business that is not closed and which provides comparable benefits, services, and terms, with no additional underwriting requirement, or (2) the plan pools the experience of the closed block of business with all appropriate blocks of business that are not closed for the purpose of determining the premium rate of any plan contract within the closed block, with no rate penalty or surcharge beyond that which reflects the experience of the combined pool.

(Health & Saf. Code § 1367.15(c).). The "pooling" provision of the Death Spiral Statute protects consumers enrolled in closed blocks from spiraling rate increases by "ensur[ing] that individuals in closed plans obtain affordable rates based on an appropriately large risk pool."[10] Hence, "pooling" is a term of art with specific meaning in the context of the Death Spiral context – namely the spreading of risk across a large risk pool of open blocks of business.

26. Enrollees in the health plans and policies at issue herein have not received written notification from Blue Shield that they are permitted to receive comparable coverage from open blocks of business without medical underwriting. Moreover, since only one high-deductible block of business has been left open, there are no "appropriate blocks of business" that are open with which Blue Shield can pool the Closed Health Plans or Closing Policies, as explained in greater detail below.

27. Section 1367.15, subdivision (g) provides that "[n]o health care service plan shall offer or sell any contract, or provide misleading information about the active or closed status of a block of business, for the purpose of evading this section." Similar provisions applicable to health insurance policies are set forth in Insurance Code section 10176.10, subdivision (e). Class Members have not been timely informed of the closure of the health plans and policies, were never informed that Blue Shield's premium increases were not based on an appropriate pooling of risk, and were never informed that they were entitled to transfer to comparable coverage without medical underwriting and that Blue Shield, in fact, had such policies available.

BLUE SHIELD'S UNLAWFUL CONDUCT

28. Blue Shield's practices with regard to closing blocks of business violate section

[10] Enrolled Bill Report on AB 1743, Consumer Services Agency, ("Enrolled Bill Report"), September 15, 1993, p. 3, (Attached as Exhibit 4 is a true and correct copy of the Enrolled Bill Report, which is incorporated herein by reference.)

1367.15 of the Health & Safety Code and section 10176.10 of the Insurance Code.

29. On December 7, 2009, Blue Shield filed a notice with the DMHC indicating that as of March 2, 2010, the following plans would be closed: "Shield Spectrum PPO 500, Shield Spectrum PPO 750, Shield Spectrum PPO 1500, Shield Spectrum PPO 1500 HIPAA GI, Shield Spectrum PPO 2000, Shield Spectrum PPO 2000 HIPAA GI, Shield Spectrum PPO 2000 Conversion, and Shield Savings 2400/4800." ("Closed Health Plans").[11]

30. The notice that Blue Shield filed with DMHC affirmed that the closing of the plans was supposedly being done in accordance with section 1367.15: "The Plan confirms that, in compliance with § 1367.15(c) of the Health and Safety Code, the Plan is pooling the experience of the above-noted closed plans ***with all appropriate open plans*** for the purpose of determining the premium rates of all of the above-noted plans, with no rate penalty or surcharge beyond that which reflects the experience of the combined pool." (Emphasis added.)

31. However, at the time of the closures, Blue Shield had ***absolutely no open*** PPO health plans regulated by the DMHC with which to pool and, in fact, had only three open HMO policies. Due to the significant structural differences, and differences in benefits, between HMO health plans and PPO health plans, HMO blocks of business are not "appropriate" blocks of business to pool with PPO blocks of business under the Death Spiral Statute. Alternatively, Blue Shield could have pooled the experience of the Closed Health Plans with appropriate CDI-regulated PPO policies open at the time that Closed Health Plans were closed. By choosing not to pool with the appropriate CDI PPO policies, Blue Shield was required to offer Class Members in the Closed Health Plans coverage that provides comparable benefits, services, and terms, with no medical underwriting. However, Blue Shield failed to provide this option to consumers. Thus, by not making comparable open block plans available at the same time it closed the above plans, Blue Shield violated both the letter and intent of the Death Spiral Statute.

32. In the third quarter of 2010, some months after the Closed Health Plans were officially closed, Blue Shield opened one DMHC-regulated PPO Plan, Shield Spectrum 5500.

[11] Attached as Exhibit 5 is a true and correct copy of Blue Shield's December 7, 2009 filing, which is incorporated herein by reference.

Shield Spectrum PPO 5500 was Blue Shield's only open DMHC-regulated PPO health plan for several months. As detailed below, even though it was not a comparable plan, Plaintiff Martin switched to that plan rather than face the stiff premium increase resulting from Blue Shield's illegal pooling practices.

33. On January 1, 2011, Blue Shield announced it was implementing an average 39.5% rate increase affecting 64,000 consumers enrolled in the eight Closed Health Plans ("2011 Rate Increase"). In response to this threatened increase, Plaintiff Martin moved his family into the only DMHC-regulated PPO plan available and the only Blue Shield PPO offered to him in response to his inquiries, the Shield Spectrum PPO 5500 plan, which offered fewer benefits and coverage compared to his former Shield Spectrum PPO 2000. Blue Shield did not ultimately implement the 2011 Rate Increase, and Mr. Martin sought to return to his former Shield Spectrum PPO 2000 plan. However, Blue Shield refused to allow Mr. Martin to transfer back to the closed Shield Spectrum PPO 2000 health plan.

34. Notably, at the time of the January 2011 rate increase, the Shield Spectrum PPO 5500 plan had just a few thousand members.

35. On March 1, 2012, Blue Shield implemented a 14.8% rate increase affecting approximately 50,000 consumers remaining enrolled in the eight Closed Health Plans ("2012 Rate Increase"). The dwindling number of consumers affected by the 2011 Rate Increase compared to the 2012 Rate Increase suggests that many consumers succumbed to the Death Spiral and may now be uninsured or underinsured if they were unable to obtain new coverage due to pre-existing conditions.

36. Blue Shield did not inform enrollees of the Closed Health Plans at the time the plans were closed of their options to change coverage, or even inform them that their health plans were in fact closed. Thus, Blue Shield did not timely offer and does not offer enrollees in the Closed Health Plans the option to enroll in plan contracts with comparable benefits, services, and terms without additional underwriting. Instead, Blue Shield either offered no PPO coverage at all, or only offered non-comparable coverage with lesser benefits. Accordingly, all persons who were members of Closed Health Plans either were trapped in a Death Spiral or received lesser

benefits than those to which they are statutorily entitled.

37. Additionally, Blue Shield did not properly pool the experience of those in the Closed Health Plans with the experience of persons in appropriate blocks of business that are not closed when determining the premiums for the closed blocks of business. As discussed above, "pooling" is a term of art with specific meaning in the Death Spiral context – namely the spreading of risk across a large pool of open blocks of business. By pooling the Closed Health Plans with either non-comparable HMO health plans or a single open block of business with *de minimis* enrollment, Blue Shield failed to pool "the experience of the closed block of business with all appropriate blocks of business," resulting in greater rate increases than statutorily allowed for the Closed Health Plans and the open Shield Spectrum PPO 5500.

38. As discussed above, under the Death Spiral Statute a health care service plan that chooses the "pooling" option must combine the experience of a closed block of business with the experience of *multiple* appropriate open blocks in order to ensure that consumers in the closed blocks "obtain affordable rates based on an appropriately large risk pool."[12] If done correctly, pooling has the effect of diluting the higher medical risk of the closed block of business over a large pool of healthier insureds, thus *decreasing* the magnitude of rate increases that those in the closed blocks would face if rates were based solely on the medical experience of the older and sicker consumers in the closed block. Here, Blue Shield did the opposite. Blue Shield later pooled the Closed Health Plans with a *single* open plan with very limited enrollment as compared to an "appropriately large risk pool" envisioned by the Legislature, which resulted in *increasing* the magnitude of the rate increase for those in the open block—due to the lack of a sufficiently large risk pool of healthy insureds—in addition to rates for those in the Closed Health Plans that are higher than statutorily allowed. In effect, Blue Shield has created one large Death Spiral containing eight Closed Health Plans and a single, small open plan. Making matters worse, since Blue Shield of California has only one high-deductible health plan available to new customers, whereas Blue Shield Life & Health Insurance Company at the time the Closed Health Plans were closed had 23 open PPO plans offering a wide variety of deductibles and benefits, Blue Shield

[12] Enrolled Bill Report, *supra* note 10, p. 3.

ensured that most new enrollees would enroll in the CDI-regulated affiliated company, thus exacerbating the effects of the Death Spiral affecting DMHC enrollees. Thus, Blue Shield's pooling of the eight Closed Health Plans with either HMO plans or a single open PPO plan with only a *de minimis* number of enrollees violates both the language and the spirit of the statute and results in higher premiums for the Closed Health Plans and the Shield Spectrum PPO 5500 health plan than is permitted by law. In essence, the Shield Spectrum PPO health plan, due to its small enrollment, is unable to effectively dilute the effect of the higher medical costs associated with the Closed Health Plans.

39. Blue Shield is set to repeat the same Death Spiral Statute violations with respect to its CDI-regulated policies. Blue Shield has announced on its public website that as of July 2, 2012, it will close the 23 PPO policies regulated by the CDI. The policies to be closed include: Active Start Plan 25, Active Start Plan 25 Generic Rx, Active Start Plan 35, Active Start Plan 35 Generic Rx, Balance Plan 1000, Balance Plan 1700, Balance Plan 2500, Essential Package 1750, Essential Package 3000, Essential Package 4500, Shield Savings 1800/3600, Shield Savings 3500, Shield Savings 4000/8000, Shield Savings 4000/8000-Guaranteed Issue, Shield Savings 5200, Vital Shield 900, Vital Shield 2900, Vital Shield Plus 400, Vital Shield Plus 400 Generic Rx, Vital Shield Plus 900, Vital Shield Plus 900 Generic RX, Vital Shield Plus 2900, Vital Shield Plus 2900 Generic Rx ("Closing Policies").[13] Blue Shield has also announced that, as of that date, as it did in March 2010 with respect to the DMHC-regulated Closed Health Plans, Blue Shield will leave just a single open high deductible non-comparable CDI-regulated PPO policy: Shield Spectrum PPO 5000. Blue Shield has not provided written notice to the individual policyholders of the Closing Policies of these imminent closures.

40. Blue Shield has also announced that it will open 11 new PPO health plans, but regulated by the DMHC not CDI. Those new health plans have not been made available to Class Members such as Ms. Goodwin who are in Closing Policies.

[13] Attached as Exhibit 6 is a true and correct copy of Blue Shield's website as of June 8, 2012, listing open and closed health plans and policies, which is incorporated herein by reference.

FACTUAL ALLEGATIONS REGARDING PLAINTIFFS

Blue Shield of California Plaintiff, Robert Martin

41. Plaintiff Robert Martin enrolled in a Shield Spectrum PPO 2000 health plan prior to 2009.

42. Mr. Martin's wife, Pamela S. Martin and son, Patrick E. Martin, are also insureds under that health plan contract.

43. Mr. Martin's previous health plan contract, Shield Spectrum PPO 2000, and current health plan contract, Shield Spectrum PPO 5500, are subject to Health & Safety Code section 1367.15.

44. Mr. Martin's former Shield Spectrum PPO 2000 health plan, and his current Shield Spectrum PPO 5500 health plan, contain the following provision related to "Statutory Requirements":

> This Agreement is subject to the Knox-Keene Health Care Service Plan Act, Chapter 2.2 of Division 2 of the California Health and Safety Code and Title 28 of the California Code of Regulations. Any provision required to be in this Agreement by reason of such Codes shall be binding upon Blue Shield of California whether or not such provision is actually included in this Agreement. In addition, this Agreement is subject to applicable state and federal statutes and regulations, which may include the Health Insurance Portability and Accountability Act. Any provision required to be in this Agreement by reason of such state and federal statutes shall bind the Subscriber and Blue Shield of California whether or not such provision is actually included in this Agreement.

One provision of the Knox-Keene Health Care Service Plan Act is Health & Safety Code section 1367.15. All of the Closed Health Plans regulated by the DMHC contained identical or substantially similar provisions. The Closing Policies, regulated by the CDI, by implication or as a matter of law, incorporate similar relevant provisions of the Insurance Code, including Insurance Code section 10176.10.

45. Robert and Pamela Martin's son, Patrick, has a lesion on his brain that his doctor's are currently monitoring but are hopeful will eventually dissipate with no long-term effects. This condition, however, prevents Patrick individually, and his family collectively, from passing medical underwriting.

46. In November 2010, Mr. Martin received a letter from Blue Shield informing him

that as of January 1, 2011, as a result of the 2011 Rate Increase, his premium for his Shield Spectrum PPO 2000 health plan would increase by 23% from $1,964 per month to $2,411 per month, a change of $447 per month.

47. Mr. Martin was not timely informed of the closure of the Shield Spectrum PPO 2000 health plan, was never informed that Blue Shield's premium increases were not based on an appropriate pooling of risk and was never informed that he was entitled to transfer to comparable coverage without medical underwriting and that Blue Shield, in fact, had such policies available.

48. In response to the threatened 2011 Rate Increase, Plaintiff Martin moved his family into the only DMHC-regulated PPO plan available and the only Blue Shield PPO offered to him by Blue Shield in response to his inquiries, which offered fewer benefits and coverage. In March 2011, Mr. Martin called Blue Shield to inquire about other health plans available to him at a lower rate. A Blue Shield representative informed Mr. Martin that the only plan available to him without medical underwriting was the DMHC-regulated Shield Spectrum PPO 5500 plan, a higher deductible plan that did not offer comparable benefits, services and terms. Mr. Martin was not offered access to any of the CDI-regulated PPO policies open at that time. Shortly thereafter, Mr. Martin switched to the Shield Spectrum PPO 5500 plan, a policy that is marginally less expensive than the Shield Spectrum PPO 2000 health plan at the increased rate (although as a result of the failure to implement the rate increase on the closed plan, not by much) but which provides significantly less coverage and thus does not provide him and his family comparable benefits, services, and terms as required by law.

49. After learning that the 2011 Rate Increase would not be implemented, Mr. Martin attempted to transfer back to his former Shield Spectrum PPO 2000 health plan. In a letter from Blue Shield dated September 8, 2011, however, Mr. Martin was informed that he would not be allowed to switch back to the Shield Spectrum PPO 2000 health plan because that plan "is a closed plan and you were transferred to an open marketed plan. Once a member transfers to an open marketed plan, we are unable to allow you to transfer back to a closed plan; unless we receive a request within 30 days from your effective date. Unfortunately, we are unable to

comply with your request."[14] However, Mr. Martin did not receive notice that the 2011 Rate Increase would not be implemented until more than ***two months after*** the effective date of the transfer of his family to the Shield Spectrum PPO 5500 plan.

50. As a result of being pushed out of his higher benefit policy by the threat of the 2011 Rate Increase, Mr. Martin suffered a loss of money and property by being forced to pay for a health plan that offers less coverage. Mr. Martin would not have moved out of his higher benefit health plan if he had received timely notice that comparable coverage was available or if the Closed Health Plans had been appropriately pooled. Mr. Martin also suffered a loss of money by having to pay $176 per month more for his Shield Spectrum PPO 5500 health plan as a result of the 2012 Rate Increase, which increase is higher than it should due to Blue Shield's illegal pooling. As discussed above, Blue Shield's pooling of the eight Closed Health Plans with a single open PPO plan with only a *de minimis* number of enrollees violates both the language and the spirit of the statute and results in higher premiums for the Closed Health Plans as well as the Shield Spectrum PPO 5500 health plan because, due to its small enrollment, the Shield Spectrum PPO 5500 health plan is unable to effectively dilute the higher medical costs associated with the Closed Health Plans.

51. Mr. Martin as well as other similarly situated consumers have thus been injured in fact and lost money or property as a result of Blue Shield's unlawful conduct in that Blue Shield has never appropriately pooled or offered them comparable coverage in accordance with section 1367.15 of the Health & Safety Code. Instead, their only option was to receive reduced coverage that did not contain comparable benefits, services and terms or be trapped in the Death Spiral and be subject to spiraling rates over time. Mr. Martin and his family were triply harmed: they were forced to move to lower-benefit coverage, then were charged an illegally inflated rate for the degraded coverage due to Blue Shield's inappropriate pooling, and then were not permitted to return to their original plan due to a lack of appropriate notice. Blue Shield has not made

[14] Attached as Exhibit 7 is a true and correct copy of the September 8, 2011, letter Mr. Martin received from Blue Shield, a March 28, 2011, letter Mr. Martin received from Blue Shield confirming his transfer to the Shield Spectrum PPO 5500 plan, and a November 2010 letter Mr. Martin received from Blue Shield informing him of the scheduled 23% premium increase, which are incorporated herein by reference.

comparable coverage available to all Class Members without medical underwriting. Blue Shield's calculation of the increased premiums for coverage under the 2011 Rate Increase and 2012 Rate Increase is not in accordance with California law. Absent injunctive relief, this harm will continue unabated.

Blue Shield Life & Health Insurance Company Plaintiff, Deborah Goodwin

52. Ms. Goodwin is challenging Blue Shield's announced July 2, 2012 closure of 23 blocks of PPO policies, which are regulated by the CDI. Ms. Goodwin has been directly affected by the imminent closure of the CDI-regulated PPO policies, and Blue Shield's plan to leave just one CDI-regulated PPO policy open and open 11 new DMHC-regulated PPO health plans. Ms. Goodwin is currently enrolled in a Shield Savings 1800/3600 PPO, which is among the CDI-regulated policies slated for closure on July 2, 2012. Ms. Goodwin has received no written notice from Blue Shield of the impending closures, nor has she been informed by Blue Shield of her rights to seek comparable coverage from an open block, or benefit from pooling of the soon-to-be closed blocks with an appropriately large pool of open blocks. She does not know if she can transfer to the single policy that will be open after July 2 and what the financial impact would be on her as compared to staying in her soon to-be-closed policy, or if Blue Shield will defer closing such policies. The only option Ms. Goodwin has been given by Blue Shield, in response to multiple phone calls Ms. Goodwin placed to Blue Shield, is the option to switch to a single, high-deductible, lower-benefit policy, *which is also slated to be closed* on July 2. Blue Shield has been unable to give Ms. Goodwin any information about which policies, if any, with or with medical underwriting, will be available to her after July 2, 2012. She has already expended tens of hours of personal time and resources attempting to determine answers to these looming questions, and thus has expended resources to avoid the consequences of such illegal practices, to no avail.

53. Ms. Goodwin has had significant health problems in the past and faces on-going medical treatment. Once the planned July 2 closures occur, Ms. Goodwin, and other consumers with pre-existing conditions trapped in the Closing Policies due to their inability to pass medical underwriting—and whose rates are based on the experience of the soon to-be-closed blocks—will suffer irreparable harm. Once the July 2 closures occur, the rating dynamics of the Closing

Policies will change forever: some consumers in the Closing Policies may be allowed to enroll in the lone open policy, receiving lesser coverage, while new healthy applicants will disproportionally enroll in the 11 soon-to-be-opened DMHC-regulated PPO health plans since those plans offer a wider selection of coverage, including more protective lower-deductible health plans.

54. If history is any indication and based on the unavailability of the CDI-regulated PPOs to those in the Closed Health Plans and only one remaining open policy, the rates of individuals in the Closing Policies like Ms. Goodwin and other Class Members will be increased by Blue Shield without it engaging in the proper pooling required by law, and Ms. Goodwin and other Class Members in the Closing Policies will not be offered new coverage from an open block with comparable benefits. Absent injunctive relief, this harm will continue unabated and Ms. Goodwin and other Class Members in the Closing Policies be unable to undo the harm that inevitably results when such policies are closed.

55. At the same time Blue Shield will close the 23 Closing Policies, it will open 11 new DMHC-regulated PPO policies, according to an announcement on the Blue Shield website. However, those new health plans have not been and will not be made available to Class Members such as Ms. Goodwin who are enrolled in the Closing Policies.

56. The imminent closure of the Closing Policies will, if implemented as currently announced with no comparable alternative coverage available, result in a violation of the Death Spiral Statute since the only remaining open CDI-regulated PPO policy after July 2, 2012 provides lesser benefits than the Closing Policies. In addition, pooling is not possible under these circumstances because the only remaining open CDI-regulated PPO policy has a far smaller enrollment than the 23 Closing Policies, and thus cannot provide an appropriately large risk pool with which to pool the Closing Policies.

BLUE SHIELD'S ILLEGAL GAMING OF CALIFORIA'S DUAL-REGULATOR HEALTH INSURANCE SYSTEM

57. Considered together, Blue Shield's practice of alternating the closures and openings of health plans and policies offered by its DMHC- and CDI-regulated affiliates

demonstrate a broader scheme being implemented by Blue Shield to illegally manipulate blocks of business in order to trap consumers in closed blocks in violation of the Death Spiral Statute.[15] First, consumers trapped in the Closed Health Plans are offered an empty choice: pay higher premiums or switch to a high deductible plan and pay slightly less for far less coverage. The 23 Closing Policies open to new enrollees at the time of the DMHC closures were not offered to the older and sicker consumers in the Closed Health Plans. Now, with the 11 soon-to-be-opened DMHC PPO policies, Blue Shield can sell new coverage to new healthy applicants while having already trapped older and sicker consumers in a Death Spiral.

58. As detailed above, Blue Shield is apparently preparing to repeat the same scheme with the CDI-regulated Closed Policies. Blue Shield will, if past experience is any indication, open new CDI policies in the future, trapping older and sicker CDI consumers in the Closed Policies subject to spiraling rates while selling new coverage to healthy consumers. The illegal gaming of the system unjustly enriches Blue Shield because it allows the company to push sicker consumers who are more expensive to insure into lower benefit, higher deductible health plans or policies that require consumers to pay more out of pocket before coverage kicks in, or "purge" the higher risk consumers by pricing them out of care altogether, while selling prime new coverage to only healthy consumers that pass medical underwriting. This is precisely what the Death Spiral Statute was designed to avoid. Thus, Blue Shield's practices with respect to its CDI-regulated policies appear to be part of an integrated scheme for which both Plaintiffs and Class Members may appropriately seek redress. The purpose of the requested injunctive relief is to protect California consumers against unfair business practices by stopping such practices in their tracks. Since an injunction would not serve the purpose of preventing future harm if only those who had already been injured by the practice were entitled to that relief, Plaintiffs and Class Members can appropriately seek such relief as such harm is either actual or imminent.

[15] Attached as Exhibit 8 is a graphic demonstrating Blue Shield's gaming of California's dual-regulator health insurance system, which is incorporated herein by reference.

CLASS ALLEGATIONS

59. This action is brought on behalf of Plaintiffs both individually and on behalf of all other similarly situated current California residents pursuant to Code of Civil Procedure section 382 and Civil Code section 1781. Plaintiffs seek to represent the following Class:

> All current California residents who are enrolled in an individual Blue Shield Closed Health Plan or who were enrolled in an individual Blue Shield Closed Health Plan at any time since March 2010, or who are presently enrolled in one of the Closing Policies.

60. The proposed Class is composed of thousands of persons dispersed throughout the State of California. The precise number and identity of Class Members are unknown to Plaintiffs at this time, but can be obtained from Blue Shield's records.

61. Common questions of law and fact predominate over any individualized questions. Common legal and factual questions include the following:

(a) Whether Blue Shield's conduct as detailed above violates section 1367.15 of the Health & Safety Code and/or section 10176.10 of the Insurance Code;

(b) Whether Blue Shield engaged in an unlawful, unfair, misleading or deceptive business act or practice with regard to the Closed Health Plans and Closing Policies;

(c) Whether Blue Shield breached its uniform express or implied agreements with Plaintiffs and Class Members, including the implied covenant of good faith and fair dealing;

(d) Whether Plaintiffs and Class Members are entitled to damages, restitution or disgorgement; and

(e) Whether Plaintiffs and Class Members are entitled to an Order enjoining Blue Shield from its present and imminent violations of law.

62. Plaintiffs' claims are typical of the claims of the Class as they both have suffered similar harm and/or are threatened with irreparable harm as set forth in detail above.

63. Plaintiffs are willing and prepared to serve the Court and the proposed Class in a representative capacity. Plaintiffs will fairly and adequately protect the interests of the Class and have no interests adverse to or which materially or irreconcilably conflict with the interests of the other members of the Class.

64. The self-interests of Plaintiffs are co-extensive with and not materially antagonistic to those of absent Class Members. Plaintiffs will undertake to represent and protect the interests of absent Class Members.

65. Plaintiffs have engaged the services of counsel listed below who are experienced in complex class litigation and the issues raised in this action, will adequately prosecute this action, and will assert and protect the rights of and otherwise represent Plaintiffs and absent Class Members.

66. A class action is superior to other available means for the fair and efficient adjudication of this controversy. The injuries suffered by individual Class Members are small compared to the burden and expense of individual prosecution of the complex and extensive litigation needed to address Blue Shield's conduct. Individualized litigation presents a potential for inconsistent or contradictory judgments or the establishment of incompatible standards of conduct. By contrast, a class action presents far fewer management difficulties; allows the hearing of claims that might otherwise go unaddressed; and provides the benefits of single adjudication, economies of scale, and comprehensive supervision by a single court.

67. Blue Shield has acted or refused to act on grounds generally applicable to the Class, thereby making appropriate final and injunctive relief with respect to Plaintiffs and members of the Class as a whole.

FIRST CAUSE OF ACTION

Violation of Business & Professions Code § 17200 *et seq.* – Unlawful Business Acts and Practices

68. Plaintiffs incorporate by reference each of the preceding paragraphs as though fully set forth herein.

69. Business & Professions Code section 17200 *et seq.* prohibits acts of "unfair competition", which is defined as including "any unlawful, unfair or fraudulent business act or practice . . . ."

70. Blue Shield's conduct, as described above, constitutes "unlawful" business acts and practices.

71. Blue Shield has violated and continues to violate Business & Professions Code section 17200's prohibition against engaging in "unlawful" business acts or practices by, *inter alia*, violating section 1367.15 of the Health & Safety Code, section 10176.10 of the Insurance Code, as well as relevant provisions of the CLRA, and systematic breach of express or implied contracts and the implied covenant of good faith and fair dealing, as set forth herein.

72. In relevant part, section 1367.15 of the Health & Safety Code and section 10176.10 of the Insurance Code requires that upon closing a block of business, a health care service plan or health insurer must pool the closed block of business with appropriate open blocks of business in order to calculate premiums or must offer alternative plan contracts that provide comparable benefits, services, and terms, with no additional underwriting requirement.

73. Blue Shield has violated and/or has announced conduct that imminently will violate section 1367.15 and section 10176.10 by failing to offer enrollees comparable alternative health plan contracts or policies without medical underwriting and/or by failing to have available appropriately large open plans or policies with which it may appropriately pool the Closed Health Plans or Closing Policies and provide notification of such a change in policy or practice.

74. Blue Shield has also violated the Death Spiral Statute by failing to timely provide material information relating to the closure of such plans and policies as set forth above, thereby disseminating misleading information regarding the Closed Health Plans and Closing Policies. For example, Blue Shield failed to explain that the plans were illegally pooled for purposes of calculating rates and that any health plans or policies made available to consumers in the Closed Health Plans and Closing Policies without underwriting are not comparable as required under the law.

75. Additionally, section 1367.15, subdivision (g) of the Health and Safety Code provides that "[n]o health care service plan shall offer or sell any contract, or provide misleading information about the active or closed status of a block of business, for the purpose of evading this section." Similar provisions applicable to health insurance policies are set forth in Insurance Code section 10176.10, subdivision (e).

76. Blue Shield has violated Health & Safety Code section 1367.15, subdivision (g)

and Insurance Code section 10176.10, subdivision (e) by:

(a) Opening the Shield Spectrum PPO 5500 health plan to provide the mere appearance of "pooling," but which—due to the *de minimis* enrollment of the Shield Spectrum PPO 5500 health plan compared to the enrollment of the Closed Health Plans—fails to provide appropriate pooling as required under the Death Spiral Statute;

(b) Failing to provide accurate information to enrollees in the Closed Health Plans regarding the availability of comparable open coverage regulated by the CDI or providing timely notice of the decision not to implement the 2011 Rate Increase such that enrollees could switch back to a particular closed plan if warranted;

(c) Threatening to close the 23 Closing Policies while leaving only a single open PPO regulated by the CDI, which—due to the *de minimis* enrollment of the open policy compared to the enrollment of the Closing Policies—fails to provide for appropriate pooling as required under the Death Spiral Statute.

(d) Failing to provide any written information to enrollees in the Closing Policies regarding the availability of comparable open coverage regulated by the DMHC, or even that such policies will soon be closed to further enrollment.

77. Plaintiffs and/or Class Members, as applicable, have been injured in fact and lost money or property as a result of Blue Shield's business acts and practices by, *inter alia*, either paying or being told they will need to pay increased premiums and/or receive lesser benefits, as well as through the expenditure of time and resources in an effort to avoid or minimize the consequences from both the closure of the Closed Health Plans and imminent closure of the Closing Policies as of July 2, 2012. These acts and practices resulted in, or will imminently result in, Plaintiffs and/or Class Members paying more for insurance or accepting lesser benefits than they would have absent Blue Shield's conduct.

78. As a result of Blue Shield's violations of the unlawful prong of the UCL, Plaintiffs and Class Members are entitled to equitable relief in the form of full restitution of all monies paid for illegally increased premiums and/or for premiums paid for decreased benefits and disgorgement of the profits derived from Blue Shield's unlawful business acts and practices.

79. Plaintiffs also seek an order enjoining Blue Shield from continuing its unlawful business practices and from engaging in the present, threatened or future conduct set forth herein.

80. THEREFORE, Plaintiffs pray for relief as set forth below as applicable to this cause of action and the appropriate members of the Class.

SECOND CAUSE OF ACTION

Business and Professions Code § 17200 *et seq.* – Unfair Business Acts and Practices

81. Plaintiffs incorporate by reference each of the preceding paragraphs as though fully set forth herein.

82. The acts of Blue Shield, as described above, individually and collectively, constitute "unfair" business acts and practices.

83. Blue Shield's conduct does not benefit consumers or competition. Indeed, the harm to consumers and competition is substantial.

84. Plaintiffs and Class Members could not have reasonably avoided the injury each of them suffered and are threatened with at this time.

85. The gravity of the consequences of Blue Shield's conduct as described above outweighs any justification, motive or reason therefore and is immoral, unethical, unscrupulous, offends established public policy, is tethered to a legislatively declared policy as set forth in the Death Spiral Statute, and/or is substantially injurious to Plaintiffs and other members of the Class as set forth in more detail above.

86. As a result of Blue Shield's violations of the UCL, Plaintiffs and Class Members are entitled to equitable relief in the form of full restitution of all monies paid for illegally increased premiums and/or for premiums paid for decreased benefits and disgorgement of the profits derived from Blue Shield's unfair business acts and practices.

87. Plaintiffs also seek an order enjoining Blue Shield from such present, future or threatened conduct.

88. THEREFORE, Plaintiffs pray for relief as set forth below as applicable and appropriate.

THIRD CAUSE OF ACTION

Business and Professions Code § 17200 *et seq.* –

Fraudulent Business Acts and Practices

89. Plaintiffs incorporate by reference each of the preceding paragraphs as though fully set forth herein.

90. Such acts of Blue Shield as described above, and each of them, constitute deceptive, misleading or "fraudulent" business practices under California Business and Professions Code section 17200 *et seq.*

91. As more fully described herein, Blue Shield's failure to inform consumers about the true nature of the Blue Shield's pooling practices and the availability of comparable coverage is likely to deceive members of the Class regarding their statutory rights. Blue Shield's misrepresentations or omissions of fact they were bound to disclose were material and were a substantial factor in decisions to stay with the Closed Health Plan and/or switch to a new open health care plan contract. Similarly, Blue Shield's failure to inform consumers enrolled in the Closing Policies of the availability of comparable coverage from the 11 soon-to-be-opened DMHC-regulated PPOs and the fact that appropriate pooling with the single open CDI-regulated PPO policy as of July 2, 2012 is not possible under the circumstances is likely to deceive consumers regarding their statutory rights.

92. Additionally, Blue Shield's omissions are likely to deceive consumers in the Closed Health Plans that rate increases are being calculated in accordance with the law when as established, they cannot be.

93. As a result of Blue Shield's violations of the UCL, Plaintiffs and Class Members are entitled to equitable relief in the form of full restitution of all monies paid for illegally increased premiums and/or for premiums paid for decreased benefits and disgorgement of the profits derived from Blue Shield's fraudulent business acts and practices.

94. Plaintiffs also seek an order enjoining Blue Shield from such present, threatened and future conduct as set forth herein.

95. THEREFORE, Plaintiffs pray for relief as set forth below.

FOURTH CAUSE OF ACTION

California Civil Code § 1750 *et seq.* –

Consumers Legal Remedies Act

96. Plaintiffs incorporate by reference each of the preceding paragraphs as though fully set forth herein.

97. Plaintiffs and Class Members are consumers insofar as they obtain the services in question for personal, family or household purposes. Blue Shield's offering of the health plans and policies in question constitute a "service" in that a significant component of the contracts in question is Blue Shield's provision of work, labor and services in connection with its providing of continuing and on-going access to its provider networks at negotiated rates.

98. Blue Shield violated and continues to violate the CLRA by engaging in the following deceptive practices, by, *inter alia*:

(a) Representing that services have sponsorship, approval, characteristics, ingredients, uses, benefits, or quantities which they do not have or that a person has a sponsorship, approval, status, affiliation, or connection which he or she does not have;

(b) Representing that a transaction confers or involves rights, remedies, or obligations which it does not have or involve, or which are prohibited by law; and

(c) Representing that the subject of a transaction has been supplied in accordance with a previous representation when it has not.

99. Blue Shield also represents that its health plans and policies are administered in compliance with state law and/or fails to disclose the material fact that its health plans and policies are not administered in compliance with state law.

100. Plaintiffs and other Class Members enrolled in the Closed Health Plans, in making decisions whether to transfer to coverage with lesser benefits or to retain their policies and pay higher premiums, reasonably acted in response to Blue Shield's representations or would have considered the omitted facts detailed herein material to their decision. Similarly, consumers enrolled in the Closing Policies have not been informed of their rights to switch to comparable open coverage, nor that future rate increases will be greater than statutorily allowed due to Blue

Shield's inability to appropriately pool the Closing Policies. Plaintiffs and/or members of the Class have suffered damage by the wrongful acts and practices of Blue Shield set forth herein, as Plaintiffs have either been forced to pay more for lesser coverage and/or expended time and resources in connection with and as a result of the acts and practices set forth above in an attempt to avoid the consequences of such conduct.

101. Written notice pursuant to the provisions of the CLRA was provided to Blue Shield on June 5, 2012. If Blue Shield fails to provide all requested relief in response to that notice, Plaintiffs will seek general, actual, consequential, statutory and exemplary damages (they do not seek such relief at this time under this cause of action). In the interim, as a result of Blue Shield's violations of the CLRA, Plaintiffs and Class Members are entitled to equitable relief in the form of full restitution of all monies paid for illegally increased premiums and/or for premiums paid for decreased benefits, an injunction to prevent Blue Shield from engaging in present or imminent conduct as set forth above, and disgorgement of the profits derived from Blue Shield's illegal business acts and practices.

FIFTH CAUSE OF ACTION

Breach of Contract

102. Plaintiffs incorporate by reference each of the preceding paragraphs as though fully set forth herein.

103. Blue Shield's uniform health plan agreements, including the Closed Health Plans, expressly incorporate by reference the provisions of the Knox-Keene Act at issue herein. The Closing Policies by implication incorporate similar relevant provisions of the Insurance Code.

104. By not pooling rates appropriately or offering comparable health plans and policies without medical underwriting for those in the Closed Health Plans, Blue Shield has withheld benefits due under the Closed Health Plans and violated the terms of these agreements. For consumers enrolled in the Closing Policies, Blue Shield's announcement that it will close 23 PPO policies as of July 2, 2012, is a clear unequivocal declaration, without justification, of Blue Shield's intent to breach their obligations under the health insurance contracts with those Class Members. Appropriate notice has been provided prior to the filing of this action by Plaintiffs to

Blue Shield.

105. Plaintiffs and Class Members as to whom such contracts have been breached have been, and will continue to be, injured by Blue Shield's breach of contract in an amount to be determined at trial.

106. THEREFORE, Plaintiffs pray for relief as set forth below as applicable to this cause of action.

SIXTH CAUSE OF ACTION

Declaratory Relief

107. Plaintiffs incorporate by reference each of the preceding paragraphs as though fully set forth herein.

108. An actual controversy over which this Court has jurisdiction now exists between Plaintiffs, the Class and Blue Shield concerning their respective rights, duties and obligations for which Plaintiffs desire a declaration of rights under the applicable agreements asserted herein, which declaration may be had before there has been any breach of such obligation in respect to which such declaration is sought.

109. Plaintiffs and Class Members may be without adequate remedy at law, rendering declaratory relief appropriate in that:

(a) relief is necessary to inform the parties of their rights and obligations under the above contracts;

(b) damages may not adequately compensate Class Members for the injuries suffered, nor may other claims permit such relief;

(c) the relief sought herein in terms of ceasing such practices may not be fully accomplished by awarding damages; and

(d) if the conduct complained of is not enjoined, harm will result to Class Members and the general public because Blue Shield's wrongful conduct is either imminent or continuing. A judicial declaration is therefore necessary and appropriate at this time and under these circumstances so the parties may ascertain their respective rights and duties.

110. Plaintiffs request a judicial determination and declaration of the rights of Class

Members, and the corresponding responsibilities of Blue Shield. Plaintiffs also request an order declaring Blue Shield is obligated to pay restitution to all members of the Class as appropriate and pay over all funds Blue Shield wrongfully acquired either directly or indirectly as a result of the illegal conduct by which Blue Shield was unjustly enriched.

SEVENTH CAUSE OF ACTION

Breach of the Implied Covenant of Good Faith and Fair Dealing

111. Plaintiffs incorporate by reference each of the preceding paragraphs as though fully set forth herein.

112. Each of the agreements identified above contain an implied covenant of good faith and fair dealing that is incorporated into all contracts as a matter of law that, *inter alia*, such contracts shall be executed consistent with the requirements of California law.

113. Blue Shield has breached its duty of good faith and fair dealing owed to Class Members in the following respects:

(a) Unreasonably closing health plans and policies without pooling their rates with an appropriately large pool of open health plans and/or policies.

(b) Unreasonably closing health plans and policies without offering comparable coverage without medical underwriting.

114. Blue Shield has breached its duty of good faith and fair dealing owed to Plaintiffs and members of the Class by other acts or omissions of which Plaintiffs are presently unaware and which will be shown according to proof at trial.

115. As a proximate result of the aforementioned unreasonable and bad faith conduct of Defendants, Plaintiffs and members of the Class have suffered and/or will continue to suffer in the future, damages plus interest, and other economic and consequential damages, in an amount to be proven at trial. As a further proximate result of the unreasonable and bad faith conduct of Defendants, Plaintiffs and members of the Class were compelled to retain legal counsel and to institute litigation to obtain the benefits due under the contracts. Therefore, Defendants are liable for those attorneys' fees, witness fees and litigation costs reasonably incurred in order to obtain their benefits under the health plan contracts.

116. Defendants' conduct described herein was intended by the Defendants to cause injury to members of the Class and/or was despicable conduct carried on by the Defendants with a willful and conscious disregard of the rights of members of the Class, subjected members of the Class to cruel and unjust hardship in conscious disregard of their rights, and was an intentional misrepresentation, deceit, or concealment of material facts known to the Defendants with the intention to deprive members of the Class property, legal rights or to otherwise cause injury, such as to constitute malice, oppression or fraud under Civil Code section 3294, thereby entitling Plaintiffs and members of the Class to exemplary damages in an amount appropriate to punish or set an example of Defendants.

EIGHTH CAUSE OF ACTION

Common Counts/Common Law Restitution, and Assumpsit

117. Plaintiffs incorporate by reference each of the preceding paragraphs as though fully set forth herein.

118. Blue Shield sold health plan contracts and policies to Plaintiffs and Class Members in blocks of business that Blue Shield subsequently chose to close without complying with applicable laws relating to such closures.

119. Blue Shield received money from Plaintiffs and many Class Members in the form of revenues and profits from increased premiums that were intended to be used for the benefit of Plaintiffs and the Class. Blue Shield accepted or retained these economic benefits with awareness that Plaintiffs and many members of the Class had improperly paid increased premiums and/or had received improperly reduced benefits for the reasons set forth above, as such amounts and benefits were not calculated in accordance with the requirements of California law. Blue Shield did not use such excess monies for the benefit of Plaintiffs and the Class nor return these excess monies.

120. Allowing Blue Shield to retain the benefits conferred by many of the Class Members under these circumstances is unjust and inequitable. There is also an implied in fact contractual obligation to provide the benefits required under California law as set forth above that was breached by the conduct set forth herein, by which Blue Shield was unjustly enriched. Under

common law principles of assumpsit, unjust enrichment and/or restitution, such excess monies must in equity and good conscience be returned to Plaintiffs and members of the Class.

121. As a result of Blue Shield's unjust enrichment in violation of these common law principles, Plaintiffs and the Class have suffered harm and thus seek an order for disgorgement and restitution of Blue Shield's excess revenues, profits and other benefits retained from improperly increased premiums and/or improperly decreased benefits in violation of California law.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs, on their own behalf and on behalf of the Class, pray for relief as follows, as applicable to the causes of action set forth above:

1. An Order certifying the proposed Class pursuant to Code of Civil Procedure section 382 and Civil Code section 1780 *et seq*. and appointing Plaintiffs and their counsel to represent the Class;

2. Declaratory Judgment stating that Blue Shield may not pursue the policies, acts and practices complained of herein;

3. An Order awarding Plaintiffs and the Class restitution and/or disgorgement and such other equitable relief as the Court deems proper;

4. Damages in an amount according to proof;

6. An Order enjoining Blue Shield from actual, threatened and imminent violations of section 1367.15 of the Health & Safety Code and section 10176.10 of the Insurance Code, Business and Professions Code section 17200 *et seq.*, the CLRA, and common law counts;

7. An Order awarding Plaintiffs and the Class pre-judgment and post-judgment interest;

8. An Order awarding Plaintiffs compensation and their counsel attorneys' fees, expert witness fees and other costs; and

9. An Order awarding such other and further relief as may be just and proper.

JURY DEMAND

Plaintiffs demand a trial by jury on all issues so triable.

DATED: June 11, 2012

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EXHIBIT 1

cc: DR DG (BM) APR 30 1993 1743 - SUPPORT

STATE OF CALIFORNIA—BUSINESS, TRANSPORTATION AND HOUSING AGENCY

PETE WILSON, Governor

DEPARTMENT OF CORPORATIONS
1107 9TH STREET, 8TH FLOOR
SACRAMENTO, CA 95814-3610

IN REPLY REFER TO:

FILE NO.

April 30, 1993

The Honorable John Vasconcellos, Chair
Assembly Ways and Means Committee
State Capitol, Room 6026
Sacramento, CA 95814

Re: Assembly Bill 1743 (Margolin)

Dear Mr. Vasconcellos:

This purpose of this letter is to inform you of the Department of Corporations' position of SUPPORT, SEEK AMENDMENTS on AB 1743. AB 1743 is scheduled for hearing in the Assembly Ways and Means Committee on Wednesday, May 5, 1993. This bill will not have a fiscal impact on the Department's existing program.

AB 1743 requires a health care service plan that closes a block of business in this state to spread the risk to other open blocks of business for the purpose of eliminating the business practice known as the "death spiral." Accordingly, this bill will help address the problem of uninsured Californians by establishing a mechanism to protect the health care coverage of individuals from a pernicious business practice that has the result of forcing individuals into the ranks of the uninsured when they need health care the most.

The Department of Corporations will continue to work with the author to provide appropriate amendments to the bill. The Department's suggested amendments place the proposed prohibition in the appropriate article of the Knox-Keene Act and revise certain terms (e.g., rate of charges, like subscribers or enrollees, and blocks of business) for the purposes of clarity and consistency with existing provisions of law. With these amendments, the Department supports this measure.

If you or your staff need additional information, please contact me at the number listed below.

Very truly yours,

TIMOTHY L. Le BAS
Senior Corporations Counsel
(916) 322-3977

TLL:jw

cc: The Honorable Burt Margolin
State Capitol, Room 4112

The Honorable Paul Horcher, Vice-Chair
Assembly Ways and Means, Room 3123

Members, Assembly Ways and Means Committee
Tim Gage, Committee Consultant, Room 6026
Tom Ross, Minority Assembly Ways and Means Consultant,
Room 3123

EXHIBIT 2

LEGISLATIVE ANALYSIS

TL:gtc

Business, Transportation & Housing Agency

DEPARTMENT	AUTHOR	BILL NO.
CORPORATIONS	Margolin	AB 1743
SPONSOR	**RELATED BILLS**	**AMENDED DATE**

SUBJECT

Health Care Service Plans: Closed Blocks

SUMMARY

Requires a health care service plan ("HCSP") that closes a block of business in this state to spread the risk to other open blocks of business for the purpose of eliminating the business practice known as the "death spiral."

ANALYSIS

A. Policy:

The Department of Corporations licenses and regulates HCSPs in accordance with the Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene Act"). Currently, the Knox-Keene Act does not require HCSPs to spread the risk of a closed block of business. AB 1743 requires HCSPs to spread the risk of a closed block of business to other blocks of business, as specified, when determining the rates to be charged for contracts included in the closed block of business. Consequently, the bill is intended to eliminate the business practice known as the "death spiral," as discussed below.

The death spiral business practice occurs when a health plan closes to new subscribers and enrollees health plan coverage under a specific book of business written under a specified policy or contract (e.g., "Policy A"). "Policy B" is then offered with similar benefits and at a lower cost to new

VOTE: SENATE FLOOR	Aye ____	No ____	VOTE: ASSEMBLY FLOOR	Aye ____	No ____
Policy Comte.	Aye ____	No ____	Policy Comte.	Aye ____	No ____

DEPARTMENTS THAT MAY BE AFFECTED:

Department of Corporations

STATE MANDATE ____ GOVERNOR'S APPOINTMENT ____ LEGISLATIVE APPOINTMENT ____

DEPARTMENT POSITION				AGENCY POSITION				GOVERNOR'S OFFICE USE	
✓	S	____	O	X	S	____	O	Position Approved	____
____	SA	____	OUA	____	SA	____	OUA	Position Disapproved	____
____	N	____	NP	____	N	____	NP	Position Noted	____
____	NA	____	NAR	____	NA	____	NAR		
		____	DEFER			____	DEFER		
DEPARTMENT B. A. Thompson BRIAN A. THOMPSON Acting Commissioner of Corporations			DATE 3/6/93	AGENCY Original Signed by Michael B. Dorais			DATE MAR 23 1993	BY:	DATE:

OP 500.297 (1/93)

subscribers and enrollees. Those subscribers and enrollees in the closed "Policy A" book of business are allowed to enroll in the new "Policy B" book of business only if they can pass a health screening. As healthy enrollees in "Policy A" leave, the number of subscribers and enrollees that cannot pass the health screening requirement of "Policy B" rises. As a consequence, the premiums for "Policy A," which are based on the experience of those contract holders in the closed book of business, begins to increase. The increasing premium cost forces additional subscribers and enrollees out of the "Policy A" book of business, which subsequently results in even higher premium increases. Through this practice, a health plan is left with only healthy subscribers and enrollees in a substantially similar book of business (i.e., under "Policy B") and a few subscribers and enrollees (i.e., those who cannot pass the new health screening requirement) under the old book of business (i.e., "Policy A"). This latter category end up paying extremely high premiums. If those "Policy A" subscribers and enrollees who cannot pass the new health screening requirement for the "Policy B" book of business cannot pay the increased premium cost, they are effectively forced out of the health plan, and likely to become uninsured.

B. Fiscal:

It is not anticipated that additional costs will be incurred by the Department of Corporations.

HISTORY

Assembly Member Margolin is sponsoring AB 1743 to eliminate the "death spiral" business practice.

The Department of Corporations has received complaints regarding this business practice, especially complains in connection with Blue Shield of California. Blue Shield's practice was also identified in a July 1992 report to the Insurance Commissioner by the Task Force on HIV/AIDS Insurance Issues.

The Department of Corporations submitted a legislative proposal (B-93-33) to the Governor's Office, to address the "death spiral" business practice. As with the Department's proposal, AB 1743 contains language based on a Wyoming statute. That Wyoming statute requires that all insurers spread their claims experience over both "open" and "closed" policy groups so that like policy holders under a substantially similar policy of health care coverage pay substantially the same premiums.

PRO AND CON

A. Argument in Support of the Bill:

This business practice, known as the "death spiral," is pernicious as it detrimentally affects individuals when they need health care the most and forces them into the ranks of the uninsured. This group will benefit greatly because premiums will be kept more in line with the rates of like subscribers and enrollees without regard to individual health problems.

B. Arguments in Opposition to the Bill:

The health care service plan industry will incur additional costs for the provision of health care for those unhealthy individuals who could not pass the health screening process for new, but substantially similar, health care contracts. These costs will be passed on to other subscribers and enrollees, who would pay more for their health coverage.

SUPPORT AND OPPOSITION

It is anticipated that consumer groups will support this proposal, as well as health care advocacy groups. It is unclear whether opposition will develop from the health plan industry, in general. Since the Department of Corporations has received a number of complaints about the "death spiral" business practice in connection with the individual health care service plan contracts issued by the Blue Shield of California, it can be anticipated that Blue Shield of California may oppose this proposal.

RECOMMENDATION

The Department of Corporations recommends a position of SUPPORT, IF AMENDED on AB 1743. This bill will help address the problem of uninsured Californians by establishing a mechanism to protect the health care coverage of those individuals from a pernicious business practice that has the result of forcing individuals into the ranks of the uninsured when they need health care the most. The Department recommends amendments to incorporate language from its legislative proposal (B-93-33). The Department's amendments are attached in Legislative Counsel format.

Contact: TIMOTHY L. Le BAS
Title: Senior Corporations Counsel
Phone Number: 322-3977

EXHIBIT 3

Date of Hearing: April 20, 1993

ASSEMBLY COMMITTEE ON INSURANCE

Burt Margolin, Chair

AB 1743 (Margolin) - As Introduced: March 4, 1993

SUBJECT

Should health insurers be required to spread the risk of closed blocks of business to blocks of business still being sold in this state?

DIGEST

Existing law requires health care service plans and health insurers to comply with various provisions of the Knox-Keene Health Care Service Plan Act and the Insurance Code, respectively. These statutes do not regulate specifically the closure of blocks of business.

This bill:

1) Requires health care service plans and health insurers that close a block of business to spread the risk of the closed block to other blocks of business still being marketed in this state when determining rates.

2) Defines "block of business" as individual, group or blanket plan or insurance contracts of a particular form.

3) Defines "closed block of business" as a block which the plan or insurer ceases to market or sell to new enrollees in this state.

FISCAL EFFECT

Undetermined

COMMENTS

1) PURPOSE. The bill is intended to address the problems experienced by people who have health coverage under "closed" plans and find themselves subjected to spiraling rate increases. An insurer "closes" a block of business by no longer offering that particular policy form or contract to new applicants. Since insurers generally require medical underwriting before accepting an applicant for coverage, those persons covered under closed plans, who happen to have pre-existing conditions, find themselves locked into the closed plan. In many instances, an insurer may offer a new, open plan with benefits similar to the closed plan. Healthy policyholders will often move from a closed plan to an open plan because the open plan, composed of healthier people who have been able to pass

- continued -

medical underwriting, will generally have lower rates than the closed plan. Over time, only unhealthy people are left in the closed plan, which leads to ever higher rates. Insurer practices in this regard have been termed the "death spiral," because rates inevitably increase to the point at which a policyholder can no longer afford the coverage.

2) OTHER APPROACHES. In the small group market (employers with three to fifty employees), the problem has been largely addressed by AB 1672 (Margolin) (Chapter 1128, Statutes of 1992), which guarantees that employers in the small group market can freely move to open plans. The language in the current measure is modeled after a Wyoming statute. Insurance Commissioner John Garamendi's Task Force on HIV/AIDS Insurance Issues issued a report last year which recommended that insurers be required to permit an insured to move to an open plan of equal benefits with no new underwriting. If the carrier has no plan of equal benefits, then the insurer would be required to pool the risk from the closed plan with all of the insurer's open plans.

3) DEPARTMENTS OF CORPORATIONS AND INSURANCE. The Department of Corporations, which regulates health care service plans, will support the bill if the author accepts technical amendments which revise certain terms for the purposes of clarity and consistency with existing provisions of law. The Department of Insurance also supports committee passage of this measure and would like to work with the author to clarify definitions in the bill.

SPONSOR: The author

SUPPORT: None received

OPPOSITION: None received

Debra Roth
445-1770
ahealth

EXHIBIT 4

Analyst Name: Marjorie Be[illegible]
Phone No.: 657-5022 / 43[illegible] N

STATE AND CONSUMER SERVICES AGENCY

ENROLLED BILL REPORT

DEPARTMENT	AUTHOR	BILL NUMBER
Office of Insurance Advisor	Margolin	AB 1743

SUMMARY

This bill requires that when a health or disability plan is closed, that the insurer place the insured in a similar plan without regard to underwriting criteria. If the insurer does not have a similar plan, it must pool the closed plan's experience with its other plans for rating purposes.

LEGISLATIVE HISTORY

AB 1672 (1992) provides that small group employers (3-50 employees) may move to open plans with no new underwriting once their plan is closed. This bill extends this policy to individuals and employer groups with fewer than three eligible employees.

The language in this bill is modeled after an unspecified Wyoming statute.

ANALYSIS

Health care service plans and disability insurers which cover individuals or employee groups with fewer than three employees must provide similar insurance without new underwriting when an existing plan is closed. This bill is intended to address what has been termed the "death spiral." When an insurer no longer offers a plan to new applicants, those insureds with pre-existing conditions are typically unable to obtain alternative insurance and remain in the closed plan.

Healthy insureds, however, often move to new open plans that are less expensive than their closed plan. Thus, the closed plan, without new applicants, becomes a plan consisting of unhealthy members so that the rates "spiral" to the point the insured no longer can afford the insurance.

The Department of Corporations implements the Knox-Keene Health Care Service Plan Act, which regulates health care service plans. Accordingly, the Office of Insurance Advisor defers to the Department of Corporations on Section 1 of this bill which applies to health care service plans.

VOTE: Assembly	VOTE: Senate
Floor: Aye 79 No 0 Policy Committee: Aye 14 No 0 Fiscal Committee: Aye 21 No 0	Floor: Aye 34 No 0 Policy Committee: Aye 8 No 0 Fiscal Committee: Aye___ No___
RECOMMENDATION TO GOVERNOR: SIGN XX VETO___	DEFER TO OTHER AGENCY_____
DEPARTMENT DIRECTOR: Marjorie M. Bentz DATE: 9/15/93	AGENCY SECRETARY: Anne E Shuman DATE: 9/15/93

Section 2 of this bill requires that a disability insurer may not close a "block of business" unless it permits the insured to move to an "open block" with no additional underwriting requirements, or that the risk of the closed block be pooled with other similar plans. A "block of business" is defined as a particular policy form that has distinct benefits or marketing methods. A "closed block of business" is defined as a block of business for which the insurer ceases to actively market and sell new individual contracts.

Two presumptions exist in determining when a block of business is closed:

(1) There has been an overall reduction of 12 percent in the number of policies of a particular plan for a period of 12 months.
(2) The plan has less than 2,000 insureds nationally or 1,000 insureds in California. This presumption does not apply to contracts initiated within the previous 24 months.

Additionally, an insurer may provide the Insurance Commissioner with evidence to rebut the presumption that the plan is closed.

If an insurer decides to close a block of business, or it determines that one of the presumptions applies, it has 30 days to provide the Insurance Commissioner with a plan to permit an insured to move to an open block providing comparable benefits with no additional underwriting requirement. Alternatively, the insurer may provide the Insurance Commissioner with a plan to pool the closed block's rating experience with other appropriate plans. Thus, the insureds in the closed plan must be ra. .d on the basis of the combined pool.

An insurer has until December 31, 1994 to bring all plans closed prior to the effective date of the statute into compliance.

This bill is not applicable to insurers providing small group insurance to individuals or employer groups with fewer than three eligible employees pursuant to Insurance Code Section 10700 et seq. (AB 1672 (1992)).

FISCAL IMPACT

The Department of Insurance and Department of Corporations will have minor additional enforcement expenses.

POSITIONS

Support:
Department of Insurance.
California Medical Association.

Opposition:
None.

RECOMMENDATION

The Office of Insurance Advisor recommends that this bill be signed.

This bill addresses a legitimate problem in which insureds with preexisting conditions are unable to obtain alternative insurance when their plan is closed. The rates for these "captive" insureds increases as healthy members of the plan move to other open plans and the risk pool becomes smaller.

AB 1672 (1992) already provides that when an insurer ceases to offer a plan to a small employer, the employer be allowed access to another small employer group plan. This bill applies this policy to disability insurers who offer health or disability insurance.

Insurance trade groups which were originally opposed to this bill have withdrawn their opposition as a result of negotiated amendments. Some insurers even support this bill because most reputable insurers do not close a block of insurance and then allow a "death-spiral" to occur. This bill addresses a problem caused by a few "marginal" companies and ensures that individuals in closed plans obtain affordable rates based on an appropriately large risk pool.

EXHIBIT 5

California Physicians' Service
dba Blue Shield of California
File No. 933-0043
Amendment No. 2353

Exhibit E-1
December 7, 2009

California Physicians' Service dba Blue Shield of California ("Blue Shield" or "the Plan") submits Amendment No. 2353, Exhibit E-1, concerning the closing of a block of business from Blue Shield's portfolio of products.

In compliance with §1367.15(e) of the Health and Safety Code, the Plan is notifying the Department of our decision to close the following plans: Shield Spectrum PPO 500, Shield Spectrum PPO 750, Shield Spectrum PPO 1500, Shield Spectrum PPO 1500 HIPAA GI, Shield Spectrum PPO 2000, Shield Spectrum PPO 2000 HIPAA GI, Shield Spectrum PPO 2000 Conversion, and Shield Savings 2400/4800, effective March 2, 2010.

The Plan confirms that, in compliance with §1367.15(c) of the Health and Safety Code, the Plan is pooling the experience of the above-noted closed plans with all appropriate open plans for the purposes of determining the premium rates of all of the above-noted plans, with no rate penalty or surcharge beyond that which reflects the experience of the combined pool.

EXHIBIT 6

Evidence of Coverage/Policy for Individuals and Families

Download complete descriptions of our grandfathered and non-grandfathered **open** IFP plans:

- Blue Shield of California Plans
- Blue Shield Life & Health Insurance Company Plans

Download complete descriptions of our **closed** IFP plans:

- Closed effective July 2, 2012
- Closed effective March 2, 2010
- Closed prior to 2010

Download complete descriptions of our open and closed IFP Specialty Benefits products:

- Open Specialty Benefits products
- Closed Specialty Benefits products

If an individual or family policy was in effect on or before March 23, 2010, the plan is considered grandfathered and exempt from many of the legislated mandates.

View descriptions for plans prior to July 1, 2012»

Open Plans

Blue Shield of California Plans

Plan	Non-Grandfathered	Grandfathered
Shield Secure Plus 2000	EOC (PDF, 480KB)	N/A
Shield Secure Plus 4000	EOC (PDF, 480KB)	N/A

Shield Secure Plus 6000	EOC (PDF, 480KB)	N/A
Shield Secure 2000	EOC (PDF, 480KB)	N/A
Shield Secure 4000	EOC (PDF, 480KB)	N/A
Shield Secure 6000	EOC (PDF, 480KB)	N/A
Shield Wise 2500	EOC (PDF, 480KB)	N/A
Shield Wise 3500	EOC (PDF, 490KB)	N/A
Shield Wise 4500	EOC (PDF, 490KB)	N/A
Shield Saver 4000	EOC (PDF, 415KB)	N/A
Shield Saver 6000	EOC (PDF, 415KB)	N/A
Access+ HMO	EOC (PDF, 420KB)	N/A
Access+ HMO-Guaranteed Issue	EOC (PDF, 420KB)	N/A
Access+ Value HMO	EOC (PDF, 420KB)	EOC-G (PDF, 420KB)
Access+ Value HMO-Guaranteed Issue	EOC (PDF, 420KB)	N/A
Shield Spectrum PPO 5500	EOC (PDF, 480KB)	EOC-G (PDF, 410KB)
Shield Spectrum PPO 5500-Guaranteed Issue	EOC (PDF, 480KB)	EOC-G (PDF, 410KB)

Blue Shield Life & Health Insurance Company Plans

Plan	Non-Grandfathered Plans	Grandfathered Plans
Shield Spectrum PPO 5000	Policy (PDF, 420KB)	Policy-G (PDF, 390KB)

Shield Spectrum PPO Plan 5000-Guaranteed Issue	Policy (PDF, 420KB)	Policy-G (PDF, 410KB)

Return to top

Closed Plans: Closed effective July 2, 2012

Closed Plans	Non-Grandfathered Plans	Grandfathered Plans
Active Start Plan 25	Policy (PDF, 410KB)	Policy-G (PDF, 410KB)
Active Start Plan 25 Generic Rx	Policy (PDF, 410KB)	Policy-G (PDF, 410KB)
Active Start Plan 35	Policy (PDF, 410KB)	Policy-G (PDF, 410KB)
Active Start Plan 35 Generic Rx	Policy (PDF, 410KB)	Policy-G (PDF, 410KB)
Balance Plan 1000	Policy (PDF, 425B)	Policy-G (PDF, 425KB)
Balance Plan 1700	Policy (PDF, 425KB)	Policy-G (PDF, 425KB)
Balance Plan 2500	Policy (PDF, 425KB)	Policy-G (PDF, 425KB)
Essential Package 1750	Policy (PDF, 415KB)	
Essential Package 3000	Policy (PDF, 415KB)	
Essential Package 4500	Policy (PDF, 415KB)	

Shield Savings 1800/3600	Policy (PDF, 500KB)	Policy-G (PDF, 500KB)
Shield Savings 3500	Policy (PDF, 500KB)	Policy-G (PDF, 500KB)
Shield Savings 4000/8000	Policy (PDF, 500KB)	Policy-G (PDF, 500KB)
Shield Savings 4000/800-Guaranteed Issue	Policy (PDF, 500KB)	Policy-G (PDF, 500KB)
Shield Savings 5200	Policy (PDF, 500KB)	Policy-G (PDF, 500KB)
Vital Shield 900	Policy (PDF, 400KB)	Policy-G (PDF, 410KB)
Vital Shield 2900	Policy (PDF, 400KB)	Policy-G (PDF, 410KB)
Vital Shield Plus 400	Policy (PDF, 430KB)	Policy-G (PDF, 435KB)
Vital Shield Plus 400 Generic Rx	Policy (PDF, 420KB)	Policy-G (PDF, 420KB)
Vital Shield Plus 900	Policy (PDF, 430KB)	Policy-G (PDF, 435KB)
Vital Shield Plus 900 Generic Rx	Policy (PDF, 415KB)	Policy-G (PDF, 420KB)
Vital Shield Plus 2900	Policy (PDF, 430KB)	Policy-G (PDF, 435KB)
Vital Shield Plus 2900 Generic Rx	Policy (PDF, 420KB)	Policy-G (PDF, 420KB)

Return to top

Closed Plans: Closed effective March 2, 2010

Blue Shield of California Plans

Closed Plans	Non-Grandfathered Plans	Grandfathered Plans
Shield Savings℠ 2400/4800	EOC (PDF, 410KB)	EOC-G (PDF, 415KB)
Shield Spectrum PPO Plan 500	EOC (PDF, 405KB)	EOC-G (PDF, 400KB)
Shield Spectrum PPO Plan 750	EOC (PDF, 400KB)	EOC-G (PDF, 400KB)
Shield Spectrum PPO Plan 1500	EOC (PDF, 400KB)	EOC-G (PDF, 405KB)
Shield Spectrum PPO Plan 1500-Guaranteed Issue	EOC (PDF, 405KB)	EOC-G (PDF, 400KB)
Shield Spectrum PPO Plan 2000	EOC (PDF, 410KB)	EOC-G (PDF, 410KB)
Shield Spectrum PPO Plan 2000-Guaranteed Issue	EOC (PDF, 405KB)	EOC-G (PDF, 400KB)

Blue Shield Life & Health Insurance Company Plans

Closed Plans	Policy
Blue Shield Life PPO Plan 1500-G	Policy-G (PDF, 420KB)
Blue Shield Life PPO Plan 1500-	Policy-G (PDF, 420KB)

Guaranteed Issue Coverage-G	
Blue Shield Life PPO Plan 2000-G	Policy-G (PDF, 420KB)
Blue Shield Life PPO Plan 2000- Guaranteed Issue Coverage-G	Policy-G (PDF, 420KB)

Return to top

Closed Plans: Closed prior to 2010

Blue Shield of California PPO Plans

Closed Plans	Evidence of Coverage
Coronet Major Benefits Plus $1,000-G	EOC-G (PDF, 240KB)
Coronet Major Benefits Plus $2,000-G	EOC-G (PDF, 240KB)
Individual Conversion Plan-G	EOC-G (PDF, 265KB)
Preferred Closed Plan $750-G	EOC-G (PDF, 260KB)
Preferred Closed Plan $1,250-G	EOC-G (PDF, 260KB)
Preferred Closed Plan $1,500-G	EOC-G (PDF, 260KB)
Preferred Open Plan $250-G	EOC-G (PDF, 260KB)
Preferred Open Plan $500-G	EOC-G (PDF, 260KB)
Preferred Open Plan $1,000-G	EOC-G (PDF, 260KB)

Preferred Open Plan $2,000-G	EOC-G (PDF, 260KB)
Preferred Special Plan $500-G	EOC-G (PDF, 260KB)
Preferred Special Plan $750-G	EOC-G (PDF, 260KB)
Senior Guard℠ Plan-G	EOC-G (PDF, 235KB)

Blue Shield of California Closed HMO Plans

Closed Plans	Evidence of Coverage
Access+ HMO-G Individual Conversion Plans	EOC-G (PDF, 255KB)
Individual HMO-G	EOC-G (PDF, 220KB)
Personal HMO-G	EOC-G (PDF, 230KB)

Return to top

Open Specialty Benefits Plans

Blue Shield of California Plans

Plan	Evidence of Coverage
Access+ HMO dental plan	EOC (PDF, 150KB)
Dental HMO plan	EOC (PDF, 180KB)
Dental PPO plan	EOC (PDF, 190KB)

Blue Shield Life & Health Insurance Company Plans

Plan	Evidence of Coverage
Specialty Duo Dental plan	EOC (PDF, 200KB)

Specialty Duo Vision plan	EOC (PDF, 130KB)
Value Smile PPO plan	EOC (PDF, 135KB)

Closed Specialty Benefit Plans

Blue Shield Life & Health Insurance Company Plans

Plan	Policy
Bridge Plan Rider for Individuals	Rider (PDF, 261KB)
Bridge Plan Rider for Individuals and Families	Rider (PDF, 261KB)
Smile PPO plan	Policy (PDF, 180KB)
Essential Dental plan	Policy (PDF, 130KB)
Essential Vision Plan	Policy (PDF, 105KB)

Return to top

EXHIBIT 7

blue of california

September 8, 2011

Robert Martin

Subscriber Name: Robert Martin

Dear Mr. Martin:

This is in response to the grievance received by Blue Shield of California (Blue Shield) on August 26, 2011, regarding a plan transfer back to the Shield Spectrum PPO℠ 2000-G health plan. You indicated in your grievance that we allow this exception, as you had switched policies to economically secure your family from the rate increases; the Shield Spectrum PPO℠ 5500 was the only choice you had to transfer to, without undergoing medical underwriting.

You have requested that Blue Shield allow you to transfer from the Shield Spectrum PPO℠ 5500 plan to the Shield Spectrum℠ PPO 2000-G health plan.

Your request has been denied for the following reasons:

- During the course of the review it has been noted you are currently enrolled in the Individual and Family Plan (IFP) Shield Spectrum℠ PPO 5500 Health Plan Effective March 25, 2011. The benefits of your insurance policy are detailed in your *Evidence of Coverage* (EOC).

- Please be advised that the Shield Spectrum PPOSM 200-G Plan is a closed plan and you were transferred to an open marketed plan. Once a member transfers to an open marketed plan, we are unable to allow you a transfer back to a closed plan; unless we receive a request within 30 days from your effective date. Unfortunately, we are unable to comply with your request.

- As indicated in your EOC, only Blue Shield's Underwriting Department can approve applications. The Underwriting Department may request additional information and/or medical records to determine an applicant's eligibility for a new health plan. If accepted, the effective date of the plan will be determined by the date the Underwriting Department completed the review of the application.

- Moreover, if you would like to transfer out of you current policy you would need to submit a 4 (four) page plan transfer application and request to transfer to an open marketed plan. Please find enclosed a copy of an application for your convenience

- The appeal review was conducted by a Blue Shield Underwriter and a Grievance Coordinator with training and experience in processing member's grievances.

You have the right to request an Independent Medical Review (IMR) through the Department of Managed Health Care (DMHC). Should your appeal meet the criteria as determined by the DMHC, the pertinent issue(s) and/or medical documentation would be reviewed by an independent review organization as selected by the DMHC. An IMR Application Form and addressed envelope have been enclosed for your convenience. Should you choose to pursue an IMR, please forward your request to the DMHC directly.

You are entitled to, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

If you have any questions or additional concerns regarding this matter, please contact me directly. If you have general questions regarding the rates of your health plan, your Installation and Membership Department are available to assist you at (800) 431-2809.

Sincerely,

Jennifer McMurtry-Hagen

Jennifer McMurtry-Hagen, Coordinator
Grievance Department
(916) 350-6031

Enclosures:

Information regarding Language Assistance Services
IMR Application
DMHC Addressed Envelope
Important Information regarding DMHC
Important Information regarding ERISA
Subscriber IFP Plan Change Request Form

blue of california

March 28, 2011

Robert Martin

RE: Health Plan Transfer

Dear Mr. Martin:

This letter is to notify you that the request to transfer your coverage to our Shield Spectrum PPO Plan 5500 made on your behalf by Ronald G Pray (Servicing Producer), has been approved at your existing tier. Enclosed you will find your new rate appendices that reflect the monthly rate. Your coverage under your new plan is effective March 25, 2011 and includes the following family members.

Subscriber	Robert Martin	Approved
Spouse	Pamela S Martin	Approved
Son	Patrick E Martin	Approved

If you have authorized Easy$Pay automatic debiting for your dues/premium, any change in the debit amount as a result of this plan change will be reflected in your next monthly or quarterly debit.

Should you need to correct any of the information provided above please contact the Blue Shield Customer Service Center at (800) 431-2809 within the next five (5) days. If we do not hear from you, we will assume these changes to your coverage are correct and accepted by you.

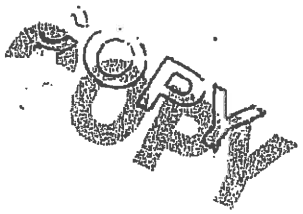
Thank you for your continuing Blue Shield membership.

Blue Shield Membership
El Dorado Hills I & M

Enclosure

CC: E41 (hd--il7f)

blue of california



November, 2010

Subscriber
Plan: PPO 2000-G

Dear ROBERT MARTIN,

We greatly appreciate the confidence you place in Blue Shield. Your membership and trust is important to us as we work to provide you with access to high-quality health coverage and excellent customer service. We're writing to let you know about upcoming benefit and rate changes to your plan.

On January 1, 2011, we are implementing benefit changes mandated by federal health reform (the Affordable Care Act) and state laws for all of our individual and family plan members. In addition, although Blue Shield remains dedicated to keeping plan and rate changes to a minimum, as healthcare costs continue to rise, we must ensure we are bringing in enough money through plan rates to cover the amount we pay out for our members' claims. Plan rates related to the increasing costs and mandates will change as of January 1, 2011 or your first billing date thereafter.

The new monthly rate[1] for your health plan is *$2.411*, a change of *$447*.

Rates change for various reasons; however an individual's rate does not increase based on that individual's use of medical services. This rate change is also not related to any increases in our administrative costs (such as salaries, rent, equipment, and other expenses).

Factors behind rates increasing include:

- **Health reform: Federal health reform changes have a very small impact on our rates, which varies by type of plan as well as "grandfathered" status (see below for information on grandfathered plans).** The average rate impact due to health reform changes is 0.9% for grandfathered plans and 4.3% for non-grandfathered plans. These increases reflect the expanded eligibility and benefits covered under the reform law. These changes are listed in a separate section of this letter and in the "Changes to your health plan" section of this book.

- **Gender-neutral rating: Effective January 1, 2011, gender can no longer be taken into account when determining an individual member's rate.** The net impact of eliminating gender-based rates is zero to the company; however, some members' rates will increase while others will decrease. The highest increase to rates resulting from gender being eliminated as a rating factor is 17.7%.

- **Rising cost of health care: Increased rates are necessary to cover the cost of medical care for our members.** Rates reflect a combination of what Blue Shield pays for health care and are directly tied to more people seeking increasingly expensive care. The rising cost of coverage continues to be driven by hospital expenses, doctor charges, and prescription drug costs. The average rate increase due to these rising expenses is 16.3%.

Benefit and health reform changes
The "Changes to your health plan" section of this booklet contains all the benefit changes and clarifications applicable to your plan. Full details are in the attached *Evidence of Coverage and Health Service Agreement* or Policy.

The following changes are being made in accordance with health reform and take effect January 1, 2011. Other health reform changes will take effect in 2014 or later.

- Dependents may now be covered in a family plan up to age 26
- Lifetime dollar limits have been removed on "essential health services"
- Preventive health services will be provided with no copayment (not applicable to grandfathered plans)
- Annual dollar limits have been removed on "essential health services" (not applicable to grandfathered plans)
- Pre-existing condition exclusions have been removed for enrollees under age 19 (not applicable to grandfathered plans)

Grandfathered plans
Under federal health reform, individual and family plans purchased on or before March 23, 2010 may now be considered grandfathered and may be exempt from some of the mandates related to the new reforms. Specialty coverage, which includes dental and vision plans, is excluded from the primary mandates of health reform for individual and family plans. There are also limitations on whether, or to what extent, a plan's benefits may be changed or updated without impacting grandfathering status of the plan. However, some of the law's benefit requirements apply to all plans, including grandfathered plans.

Grandfathering rules were added to health reform to help ensure that everyone who liked the health plan they already had may keep it as is, with only minimal changes. Your plan is considered grandfathered if you remain on the same health plan that you were enrolled on as of March 23, 2010.

Please keep in mind, if you transfer out of a grandfathered health plan, you will lose your plan's grandfathered status. Such a change could impact what type of benefits and rates are available to you since not all health reform provisions apply to grandfathered and non-grandfathered plans in the same way.

The most up-to-date information on health reform, including rules about what changes can be made to a grandfathered plan without affecting grandfathered status, is available at **blueshieldca.com/healthreform**. Information is also available from the U.S. Department of Health and Human Services at **www.healthcare.gov**.

In addition to providing reliable health coverage, Blue Shield undertakes many programs designed to reduce costs while improving the quality of care for you and all our members. You can learn more about these programs, including disease and complex care management, hospital quality improvement initiatives, and preventive care and wellness services, among others, at **blueshieldca.com**.

We understand you may be frustrated with rising health coverage rates. Let us work with you to see how to make the most of your current plan or help you determine if a different plan would better suit your individual situation and budget, while still providing you with the right level of health coverage protection in the event of the unexpected. Once you have been enrolled in your current plan for 18 months or more (and every 12 months thereafter), you can transfer to another Blue Shield plan that has the same or lesser benefits, as determined by Blue Shield, without a review of your medical history.[2]

For help with questions about your plan changes and coverage options, please contact RONALD PRAY at (408) 842-5112, or you can reach Blue Shield directly at **(866) 529-2194**, Monday through Thursday from 8 a.m. to 5 p.m., and Friday from 9 a.m. to 5 p.m.

Thank you for your membership and for the continued opportunity to serve you.

Sincerely,

Douglas King
Vice President
Individual and Small Group Business

[1] Based on our records as of October 2010. If you made changes to your plan after October, this rate does not reflect those changes. Please note that your next birthday could place you in a new age bracket resulting in a new rate at that time.

[2] If you transfer to another plan without underwriting, you will not be able to transfer back to your original plan. Blue Shield of California and Blue Shield of California Life & Health Insurance Company each has a list of plans ranked in order of benefits. The right to transfer plans is not available to individuals in a guaranteed issue, individual conversion, or MRMIP Graduate plan.

EXHIBIT 8

Blue Shield's "Death Spiral" Scheme